

<b>Case Number:</b>	CM14-0001495		
<b>Date Assigned:</b>	04/28/2014	<b>Date of Injury:</b>	11/18/2011
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 45-year-old male who reported injury on 11/18/2011. The mechanism of injury was unspecified. His diagnoses included lumbar radiculopathy, disc protrusion, degenerative disc disease, right avascular necrosis, right hip degenerative joint disease, and lumbar facet joint arthropathy. His past treatments included medications. On 01/02/2014, the injured worker complained of bilateral low back pain that radiated to the right buttocks, right posterior thigh, right posterior calf, and right Achilles with numbness and paresthesias rated 9/10. The physical examination revealed tenderness upon palpation of the lumbar paraspinal muscles. Lumbar range of motion was indicated to be restricted in all directions. The injured worker was indicated to have positive provocative maneuvers tests and a positive straight leg raise on the right. He was also indicated to have negative nerve root tension signs and clonus, Babinski, and Hoffmann's signs bilaterally. The injured worker's muscle strength was noted to be decreased. His relevant medications included atenolol, medical THC, Norco 10/325 mg, and Nucynta 100 mg. The treatment plan included Norco 10/325 mg to improve pain with maintenance of activities of daily living and Nucynta for improvements of the injured worker's pain with maintenance of activities of daily living and pain control. A Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**NUCYNTA ER 100MG #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) TWC, ONLINE EDITION, PAIN CHAPTER (CHRONIC), TAPENTADOL (NUCYNTATM)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Tapentadol (Nucynta)

**Decision rationale:** The request for Nucynta ER 100 mg #60 is not medically necessary. According to the Official Disability Guidelines, Nucynta is recommended only as a second line therapy for patients who develop intolerable adverse effects with first line opioids and also for management of chronic osteoarthritis of the knee and low back. The injured worker was indicated to have been on Nucynta for an unspecified duration of time. However, there was lack of documentation indicating the injured worker had developed intolerable adverse side effects to first line opioids. There was also a lack of documentation to indicate the injured worker had chronic osteoarthritis of the knee or low back. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**NORCO 10/325 MG #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going management Page(s): 78.

**Decision rationale:** The request for Norco 10/325 mg #150 is not medically necessary. According to California MTUS Guidelines, patients on opioid regimens should be monitored and have documentation of pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant or non-adherent drug related behaviors. The injured worker was indicated to have been on Norco for an unspecified duration of time. However, there was a lack of documentation in regard to objective functional improvement, objective decrease in pain, and evidence of monitoring for drug related behaviors or side effects with the medication. In the absence of the above, the request is not supported by the evidence based guidelines. A weaning schedule is recommended. As such, the request is not medically necessary.